Claims Appeal Process Rules Enforcement Delayed Again

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The DOL, HHS, and the IRS (the Departments) have been issuing regulations in several phases related to provisions of the Affordable Care Act (ACA) pertaining to standards for internal claims appeals and external review. These provisions apply to all non-grandfathered plans effective on plan years beginning after September 23, 2010.

The Departments published interim final regulations on July 23. On September 20, 2010, the DOL issued Technical Release 2010-02 (T.R. 2010-02), which delayed enforcement for compliance with certain provisions of the rules until July 1, 2011.

The Departments have now issued a second enforcement delay. Technical Release 2011-01, released March 18th, extends the enforcement grace period for some provisions of the law until plan years beginning on or after January 1, 2012.

Important Note Regarding Fully-insured vs. Self-funded Plans

While these rules apply to both fully insured and self-funded plans, it is important to recognize that for fully-insured plans the rules apply directly to the insurance carrier (referred to as the "Issuer" in the law and regulations). Employers who sponsor fully-insured plans will rely on the insurance carrier to administer the claims appeal process, just as they have under prior rules.

On the other hand, employers who sponsor self-funded health plans are responsible to assure that their plan has implemented the appropriate internal appeal and external review procedures. Self-funded employers should consult with their administrator to determine what level of compliance support the administrator will provide to the employer's plan. An administrator's involvement, and ability to provide services that would assist the self-funded employer with their compliance obligations, may vary from firm to firm.

Internal Appeal and External Review Rules Background

The ACA requires that group health plans and health insurance issuers, that are not grandfathered health plans, implement an expanded internal claims and appeals process. As mentioned above, the 2010 interim final regulations apply directly to health insurance issuers, in addition to group health plans. The 2010 interim final regulations provide the following standards for internal claims and appeals processes:

1. Expands adverse determinations eligible for appeals to include rescission of coverage.
2. A plan must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care no later than 24 hours after the receipt of the claim.
3. Plans are required to provide the claimant (free of charge) with new or additional evidence considered by the plan or issuer in connection with the claim.
4. Conflicts of interest provisions must be adopted by the plan including that decisions regarding hiring, compensation, or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, must not be based upon the likelihood that the individual will support the denial of benefits.
5. Notices must be provided in a culturally and linguistically appropriate manner.
6. Notices to claimants related to a claim denial must provide additional content. Specifically:
    a. Any notice must include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), the diagnosis code, and the treatment code.
    b. The reasons for an adverse benefit determination must include the denial code, as well as a description of the plan's standard, if any, that was used in denying the claim.
    c. The plan must provide a description of

internal appeals and external review processes, including information regarding how to initiate an appeal.

d. The plan or issuer must disclose the contact information for an applicable office of health insurance consumer assistance or ombudsman established under the law.

7. If a plan or issuer fails to strictly adhere to all the requirements of the 2010 interim final regulations, the claimant is deemed to have exhausted the plan's or issuer's internal claims and appeals process, and the claimant may initiate any available external review process or remedies available under ERISA or under State law.

Details of the Delay

Technical Release 2011-01 extends the enforcement grace period until plan years beginning on or after January 1, 2012 with respect to the following:

- Standard #2 (regarding the timeframe for making urgent care claims decisions),
- Standard #5 (regarding providing notices in a culturally and linguistically appropriate manner),
- With respect to standard #6 (requiring broader content and specificity in notices), the Departments are extending the enforcement grace period in part only. Specifically, with respect to the requirement to disclose diagnosis codes and treatment codes.
- Standard #7 (regarding substantial compliance).

During the grace period, the Departments will not take any enforcement action against a group health plan with respect to these provisions.

Action Steps

As stated above, employers who sponsor fully-insured health plans have little to do on a practical level since the appeals process will generally be administered by the health insurance carrier. Employers who sponsor self-funded plans should work closely with the plan administrator to determine the level of appeal process support the administrator will provide to the employer's plan to assure compliance within the required timelines.